WISCONSIN MEDICAID
RURAL HEALTH CLINIC SETTLEMENT DETERMINATION INSTRUCTIONS

Wisconsin Medicaid requires information to enable Medicaid to certify providers and to authorize and pay for medical services provided to eligible recipients.

Personally identifiable information about Medicaid providers is used for purposes directly related to Medicaid administration such as determining the certification of providers or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

The use of this form is voluntary, but providers must collect and maintain all information on the form in some format if they wish to submit a cost report.

INSTRUCTIONS: The Rural Health Clinic Settlement Determination form is to be completed by provider-based and independent rural health clinics (RHCs) and submitted to Wisconsin Medicaid along with the following forms, which constitute the annual cost report:

- Rural Health Clinic Trial Balance of Expenses, Reclassifications, and Adjustments (for provider-based RHCs *only*).
- Rural Health Clinic Statistical Data Form (for provider-based and independent RHCs).
- Rural Health Clinic Commercial Insurance-Primary/Medicaid-Secondary Encounters Submitted to Medicaid HMOs Form (for provider-based and independent RHCs).

This form determines the:

1. Allowable overhead and total cost of RHC services — provider-based RHCs only (Part A).
2. Medicaid rate per encounter (Part B).
3. Summary of RHC settlement (Part G).

Part A: Total Cost of Rural Health Clinic Services

Only provider-based RHCs should complete Part A. Independent RHCs, begin at Part B.

Part A determines the total costs, including applicable overhead costs, of RHC services provided within the reporting period. Part A requires information from the Trial Balance of Expenses, Reclassifications, and Adjustments form, which is completed by provider-based RHCs only.

Part B: Medicaid Encounter Rate Determination

Part B determines the RHC rate per encounter.

Use the following guidelines for Line 3:

- Provider-based RHCs in hospitals with fewer than 50 beds: Enter the cost-based rate per encounter from Part A, Line 11.
- Provider-based RHCs in hospitals with 50 or more beds: Enter the maximum payment rate from Part B, Line 2, for all dates of service (DOS).
- Independent RHCs: Refer to the Medicare cost report, HCFA Form 222-92, and enter the amount from Worksheet C, Part II, Line 10.

Part C: Medicaid-Only Encounter Reimbursement

Part C determines the net reimbursement for Medicaid-only encounters with DOS within the reporting period.

Use the following guidelines for Lines 2 and 3*:*

- Report encounters submitted to Wisconsin Medicaid or Medicaid HMOs separately.
- Report commercial insurance-primary/Medicaid-secondary encounters with no commercial insurance payments, even if the recipient's record indicates third-party insurance.

For Lines 6a and 6b, report Medicaid fee-for-service payments and Medicaid HMO payments separately.

Part D: Medicare/Medicaid Crossover Encounter Reimbursement

Part D determines the net reimbursement for Medicare/Medicaid crossover encounters with DOS within the reporting period.

On Line 2, report Medicare/Medicaid crossover encounters.

Lines 4, 5, 6, and 7a calculate the allocation of Medicare payments for encounters based on the Medicare cost report.

On Line 7b, report Medicaid fee-for-service payments received for Medicare/Medicaid crossover encounters.

Part E: Commercial Insurance-Primary/Medicaid-Secondary Encounter Reimbursement

Part E determines the net reimbursement for commercial insurance-primary/Medicaid-secondary encounters with DOS within the reporting period.

Refer to the RHC Provider Summary Report (PSR) and complete the Rural Health Clinic Commercial Insurance-Primary/Medicaid-Secondary Encounters Submitted to Medicaid HMOs form to prepare encounter data for Part E.

On Lines 1 and 2, report commercial insurance-primary/Medicaid-secondary encounters submitted to Wisconsin Medicaid and to Medicaid HMOs separately.

On Lines 3 and 4, the allowable cost is the lesser of the charge or encounter rate for each individual encounter. On Line 3, refer to the PSR for the total allowable costs for commercial insurance-primary/Medicaid-secondary encounters submitted to Wisconsin Medicaid.

On Line 4, insert the sum of the total of Column 9 for the Commercial Insurance-Primary/Medicaid-Secondary Encounters Submitted to Medicaid *HMOs* form.

On Line 6a, report commercial insurance payments from commercial insurers. Refer to the PSR for the total of commercial payments received for insurance-primary/Medicaid-secondary encounters submitted to Wisconsin Medicaid. Add this amount to the total of Column 10 from the Commercial Insurance-Primary/Medicaid-Secondary Encounters Submitted to Medicaid HMOs form.

On Lines 6b and 6c, include Medicaid payments received for encounters with dates of service within the reporting period. Refer to the PSR for the sum of Medicaid payments received for commercial insurance-primary/Medicaid-secondary encounters submitted to Wisconsin Medicaid, and add this amount to the total of Column 11 of the Commercial Insurance-Primary/Medicaid-Secondary Encounters Submitted to Medicaid HMOs form.

Part F: Commercial Insurance-Primary/Medicare/Medicaid Encounter Reimbursement

Part F determines the net reimbursement for commercial insurance-primary/Medicare/Medicaid encounters with dates of service within the reporting period.

Refer to the PSR to prepare encounter data for Part F.

On Line 1, enter the total number of commercial insurance-primary/Medicare/Medicaid encounters submitted to Wisconsin Medicaid.

On Line 2, the allowable cost is the lesser of the charge or encounter rate for each individual encounter. Refer to the PSR for the total allowable *costs* for commercial insurance-primary/Medicare/Medicaid encounters submitted to Wisconsin Medicaid.

On Line 4a, report commercial insurance payments from commercial insurers. Refer to the PSR for this information.

For Line 4b, report Medicaid fee-for-service payments received for commercial insurance-primary/Medicare/Medicaid encounters. Refer to the PSR for this information.

Line 4c calculates the allocation of Medicare payments for encounters within the reporting period based on the Medicare cost report.

Part G: Summary Rural Health Clinic Settlement

Part G represents the balance due to (or from) the provider for the reporting period.

Lines 1 through 4 represent net reimbursement by encounter type.

On Line 5a, enter the total sum of quarterly payments received from Wisconsin Medicaid.

On Line 5b, enter the total amount due to the provider in copayments from Medicaid recipients. This amount may be different from the amount actually received by the provider if all copayments have not been paid.

Line 6 represents the year-end settlement amount and indicates the balance due to (or from) the provider.